MEDIA, PA – Today, Congressman Joe Sestak, the highest ranking Veteran in Congress, issued the following statement in response to a recently released report by the Long Term Care Institute, which found that the Department of Veterans Affairs (VA) nursing home in Philadelphia failed to provide a sanitary and safe environment for their residents, and placed Veterans at serious risk of harm.

“As a Navy Veteran of 31 years, and the son of a WWII Veteran, I believe we have no greater duty than to serve our nation’s Veterans with the same respect and dignity with which those brave men and women served us. In recent months, I have grown increasingly troubled by reports -- past and present -- that give rise to concern of a lingering lack of consistent care and accountability within the VA. Just last week, it was reported that researchers at the VA Medical Center (VAMC) in Philadelphia broke federal law by drawing blood samples from Veterans for a research project without their knowledge. Then, this weekend, we learned -- only after a Freedom of Information Act request was filed -- that some Veterans were being subjected to substandard, potentially neglectful, care at the most vulnerable point in their lives. In both cases, I am reminded of the long-term consequences of government’s failure for over two decades -- both in the Executive Branch and Congress -- to treat Veterans and their families in a responsible and accountable way.

“I have the greatest respect for Secretary of Veterans Affairs General Eric Shinseki, but over the past several months I have corresponded with the him regarding past failures of accountability in the VA. In June, for example, I wrote to Secretary Shinseki regarding an investigation to determine how 92 prostate cancer patients at the Philadelphia VAMC were treated with excessively high or low levels of brachytherapy radiation due to carelessness and a lack of oversight. And in August, I expressed my dismay at reports that millions of dollars in improper performance bonuses were assigned to senior VA managers in 2007 and 2008, while hundreds of thousands of Veterans disability claims remained backlogged. Both occurred prior to the Secretary’s tenure.

“Today, I am once again writing to Secretary Shinseki regarding what I believe is another past systemic failure of accountability. In view of these recurring reports of past failures at the Philadelphia VA, the present leadership must do more to ensure the public that it is taking all possible steps to make it a premier center of transparency as well as accountability, today. What concerns me is that a Freedom of Information Act request was required to bring this latest revelation of poor care to light. At issue is the very credibility of one of our nation’s most important and visible health care providers and that of our government itself. If there are any other instances of inadequate VA care, they should be revealed immediately and confirmation offered that appropriate corrective action has been taken. Without such verifiable assurance,

the goals of the current administration and the hard work of the 110th and 111th Congress, to finally provide our Veterans the care and resources they have been denied for so long, will be compromised. My objective is to work with him and redouble efforts in Congress and the VA to assure our citizens, Veterans, and their families that transparency, oversight, and accountability are integral to every aspect of the VA's management and leadership. As part of this, enhanced transparency by the local VA is needed to demonstrate that the new accountability systems and assessments that have been in the process of being put into place are implemented.

"With regard to this specific case at the nursing home in West Philadelphia, I am aware that there were two inspections, one by the Inspector General of the VA and one by the Joint Commission on Accreditation of Health Care Organizations, both of which concluded that the facility met quality standards based on the metrics used. However, it took a separate VA investigation by the Long Term Care Institute -- using a different set of inspection criteria-- to identify the serious problems at the facility under its old leadership. This gives rise to the following questions, which I included in my letter to Secretary Shinseki:

• Why were the cases of abuse that occurred at the nursing home in West Philadelphia not revealed in the VA's previous inspections of the facility?
• Why did it take a Freedom of Information Act request to find out about the mistreatment of our Veterans at the nursing home in West Philadelphia?
• What is the current protocol for inspection? And what changes have been made since the VA became aware of the report?
• What is needed from Congress to ensure that inspections are properly conducted and remedial actions taken swiftly?
• If it is a funding issue, what programs are in need of assistance to prevent future mistreatment?

"What we need -- what our veterans deserve -- is accountability. That is why, this weekend, I spoke again with the VA Chief of Staff John Gingrich; Richard Citron, Director of the Philadelphia VA facility; and Mike Moreland, Network Director of the Veterans Integrated Service Network, regarding accountability and oversight of the facility.

"In my letter to Secretary Shinseki, I also noted that I believe there should be mandatory unannounced inspections at irregular intervals -- with the correct inspection metrics -- at VA facilities while the VA addresses the root causes of past failures to prevent new ones. I propose Congressional oversight should be involved in these future inspections and the results be made available to the public on the House Veterans' Affairs Committee and VA websites. I am also calling on the Congressionally Chartered Veterans Service Organizations to work with the VA

to work together to establish a collective, cooperative effort to ensure appropriate standards for medical care are consistently met at every VA facility.

“I have confidence that General Shinseki and the employees of the VA can ensure that organization one of the premier health care systems in our nation. To realize that goal, the VA’s leadership under General Shinseki must establish and uphold the highest possible standards of transparency, oversight, and accountability. The honor of our Veterans -- past, present, and future -- as well as their families deserve nothing less. Continued failures to properly treat our nation’s heroes are unacceptable. I look forward to sitting down with General Shinseki, Michael Moreland, and the Directors of our regional VAMCs to discuss this matter,” said Congressman Sestak.

Below, please find the text of the letter sent by Congressman Sestak to Secretary Shinseki:

The Honorable Eric K. Shinseki
Secretary
United States Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420-0002
Dear General Shinseki,

I am deeply concerned with the recent report in the Philadelphia Daily News regarding Veterans being mistreated at the Philadelphia VA Medical Center. The nursing home, according to the report, "failed to provide a sanitary and safe environment for their residents." Some of the examples cited in the news report, if accurate, shock the conscience.

In recent months, I have grown increasingly troubled by reports -- past and present -- that give rise to concern of a lingering lack of consistent care and accountability within the VA. Just last week, it was reported that researchers at the VA Medical Center (VAMC) in Philadelphia broke federal law by drawing blood samples from Veterans for a research project without their knowledge. Then, this weekend, we learned -- only after a Freedom of Information Act request was filed -- that some Veterans were being subjected to substandard, potentially neglectful, care at the most vulnerable point in their lives.

I have written several letters to your office over the past several months on behalf of Veterans. One regarded an investigation to determine how 92 prostate cancer patients at the Philadelphia

VAMC were treated with excessively high or low levels of brachytherapy radiation due to carelessness and a lack of oversight. And in August, I expressed my dismay at reports that millions of dollars in improper performance bonuses were assigned to senior VA managers in 2007 and 2008, while hundreds of thousands of Veterans disability claims remained backlogged. Both occurred prior to the Secretary's tenure.

Today, I am once again writing with regard to what I believe is another past systemic failure of accountability. In view of these recurring reports of past failures, the present Philadelphia VA must do more to ensure the public that it is taking all possible steps to make it a premier center of transparency as well as accountability, today. What concerns me is that a Freedom of Information Act request was required to bring this latest revelation of poor care to light. At issue is the very credibility of one of our nation's most important and visible health care providers and that of our government itself. If there are any other instances of inadequate VA care, they should be revealed immediately and confirmation offered that appropriate corrective action has been taken. Without such verifiable assurance, the goals of the current administration and the hard work of the 100th and 111th Congress, to finally provide our Veterans the care and resources they have been denied for so long, will be compromised. My objective is to work with you and redouble the efforts in Congress and the VA to assure our citizens, Veterans, and their families that transparency, oversight, and accountability are integral to every aspect of the VA's management and leadership. As part of this, enhanced transparency by the local VA is needed to demonstrate that the new accountability systems and assessments that have been in the process of being put into place are implemented.

With regard to this specific case at the nursing home in West Philadelphia, I am aware that there were two inspections, one by the Inspector General of the VA and one by the Joint Commission on Accreditation of Health Care Organizations, both of which concluded that the facility met quality standards based on the metrics used. However, it took a separate VA investigation by the Long Term Care Institute -- using a different set of inspection criteria-- to identify the serious problems at the facility under its old leadership. To better understand any root cause of this failure and to work toward solutions, I am requesting answers to several questions:

• Why were the cases of abuse that occurred at the nursing home in West Philadelphia not revealed in the VA's previous inspections of the facility?
• Why did it take a Freedom of Information Act request to find out about the mistreatment of our Veterans at the nursing home in West Philadelphia?
• What is the current protocol for inspection? And what changes have been made since the VA became aware of the report?
• What is needed from Congress to ensure that inspections are properly conducted and remedial actions taken swiftly?

• If it is a funding issue, what programs are in need of assistance to prevent future mistreatment?

For too long, people have been left with the impression that there is a culture of unaccountability. But for over two decades, Congress has neither funded the VA as it should nor taken the sort of personal interest in the challenges and frustrations of the VA staff and patients that it should. I have personally met Veterans at these facilities and my office has handled case after case of Veterans looking for help in dealing with the VA.

That said, I believe there should be mandatory unannounced inspections at irregular intervals -- with the correct inspection metrics -- at VA facilities while the VA addresses the root causes of past failures to prevent new ones, and that Congressional oversight should be involved in these inspections and the results be made available to the public on the House Veterans' Affairs Committee and VA websites. I am also calling on the Congressionally Chartered Veterans Service Organizations to work with the VA, to work together to establish a collective, cooperative effort to ensure appropriate standards for medical care are consistently met at every VA facility.

As you know, I have confidence that you and the employees of the VA can ensure that organization is one of the premier health care systems in our nation. To realize that goal, the VA's leadership must establish and uphold the highest possible standards of transparency, oversight, and accountability. The honor of our Veterans -- past, present, and future -- as well as their families deserves nothing less. Continued failures to properly treat our nation's heroes are unacceptable. I look forward to sitting down with you, Michael Moreland, and the Directors of our regional VAMCs to discuss this matter.

Warmest Regards,

Joe Sestak
Member of Congress

Born and raised in Delaware County, former 3-star Admiral Joe Sestak served in the Navy for 31 years and now serves as the Representative from the 7th District of Pennsylvania. He led a series of operational commands at sea, including as Commander of an aircraft carrier battle group of 30 U.S. and allied ships with over 15,000 sailors and 100 aircraft that conducted operations in Afghanistan and Iraq. After 9/11, the Congressman was the first Director of "Deep Blue," the Navy's anti-terrorism unit that established strategic and operations policies for the "Global War on Terrorism." He served as President Clinton's Director for Defense Policy at the National Security Council in the White House, and holds a Ph.D. in Political Economy and Government from Harvard University. According to the office of the House Historian, the Congressman is the highest-ranking former military officer ever elected to the U.S. Congress.